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APPLICATION FOR ACCESS TO CONFIDENTIAL VITAL RECORDS DATA
FOR HEALTH RELATED RESEARCH

New Hampshire Vital Records birth and death certificate data are available for health related research purposes only by application to, and approval of the Vital Records Privacy Board for Health Related Research (Privacy Board) under a process governed by state statute RSA 126:24-d, Disclosure of Information From Vital Records and the federal Health Insurance Portability and Accountability Act.

This Application for Access to Vital Records Data for Health Related Research form provides the information the Privacy Board requires to make a decision about whether or not to grant the request for data. The Privacy Board will consider your request only upon receipt of a completed application. Any areas of this application left blank without explanation will delay the review of this request, so please take the time to review your completed application carefully. Please provide responses to the questions in the application in this document only. In addition, you will be required to read and sign a Data Use Agreement (DUA) upon approval of your data request. Please reference accompanying document.

The approval process generally takes approximately four to eight weeks from the time a completed application is received by the Privacy Board. The Privacy Board meets monthly to review requests. Applicants will be notified of the status of a request after the Privacy Board's monthly meeting.

Prior to receipt of data, applicants will be notified of any fees that may be required to be paid in order to receive the requested data.

If the Privacy Board ascertains that part or all of a request can be accomplished through receipt of aggregate data, public use data sets, or creation of proxy variables, it reserves the right to deny the request and redirect the applicant to the appropriate agency to obtain the information required.

The Privacy Board reserves the right to independently validate anything contained in this application and may at its discretion contact any Institutional Review Board that has purview over the research project for which data is requested.

Please send completed application materials to the following address:

*Claire Gendron
Executive Secretary
Vital Records Privacy Board For Health Related Research
Division of Public Health Services
Department of Health and Human Services
29 Hazen Drive
Concord, NH 03301-6504*

For questions, please do not hesitate to contact us at (603) 271-4988 or e-mail to Claire.Gendron@dhhs.state.nh.us.

This form, as well as the Renewal and Termination Request forms are available online at: <http://www.dhhs.nh.gov/dphs/hsdm/publications.htm>.

Part I: Request for Data With Personal Identification Information

All information provided in these sections and in the separate data element forms is required. This information will serve as criteria for the Privacy Board's decision regarding release of confidential data.

Section A: Individual and Organization Requestor Information

Contact Person's Name and Title (name of person who will receive the data):
Organization:
Address:
Telephone Number:
Fax Number:
E-mail Address:
Principal Investigator or Overall Responsible Party's Name and Title:
Principal Investigator or Overall Responsible Party's Telephone Number:
Application Date:

Section B: Summary of Research Study Protocol or Project Activities:

Please submit a copy of your research/study/project protocol. Use as much space as you need below to answer the questions. If you are not using this electronic document, attach a separate document with numbered answers.

- 1. Title of study or project:**
- 2. Purpose of the study or project.** What is the hypothesis? How will this study benefit New Hampshire residents and/or contribute to general knowledge?
- 3. Requestor and Principal Investigator's qualifications and affiliation** (*briefly describe and attach resumes*)
- 4. Personnel.** Please describe all research and other staff who will have access to the confidential data. These include personnel, subcontractors, and affiliated agencies.
- 5. Source of funds.** Please describe the source(s) and duration of all funding for the study (including in-kind contributions). Identification should include the name, address, and a contact number for the agency directly responsible for the funding, as well as identifying links to any umbrella organization.
- 6. Study background and design.** Please address the following points. Please note, an attached protocol shall not serve as a replacement for providing answers to the questions below:
 - What are the specific aims of your project? Specifically state the goal(s) of the research. This should be as focused and detailed as possible.
 - Based on the study goal(s) and design of the information to be collected, provide an outline of the study, intended start and completion dates, and sampling or data collection methodology.
 - Describe the study's case definition (demographics, medical criteria, geographic location, and other appropriate descriptions).
 - Describe the method of data analysis and software programs you anticipate using.
 - If you intend to link data to other databases, resulting in the determination of additional individuals' identifying data being added, please describe the process and provide IRB approval to conduct this research (indicating procedures for gaining consent) with or without these individuals' consent. Include any copies of informed consent forms.

7. **IRB approval.** If applicable, please include the current documentation of the Institutional Review Board approval for the study. The IRB of record shall be in compliance with the requirements of the U.S. Department of Health and Human Services Code of Federal Regulations for Protection of Human Subjects (45 CFR 46). If not applicable, please state below.
8. **Datasets requested.** Please check all requested datasets and the time period you require for your project.

<i>Dataset Requested</i>	<i>Years Required for Project</i>
<input type="checkbox"/> Vital Records (Death)	
<input type="checkbox"/> Vital Records (Birth)	

Note: if your study anticipates requesting records into the future, please indicate final year that will be requested.

9. **Records requested.** Will a specific list of records being requested be sent to the Privacy Board or will the selection of records be based on a set of criteria?

You **shall** also refer to and complete a variable/element list form (**Appendix A**) for each dataset requested; the variable list forms require justification for all confidential data elements requested.

10. **Estimated number of records.** What is the estimated number of records/files you are requesting (if known)?

11. **Data will be provided in a password-protected encrypted file that will be uploaded to a secure site on the DHHS server. Please indicate how you would like to receive the data (check only one box):**

<input checked="" type="checkbox"/> File Format	
<input type="checkbox"/> MS Access	<input type="checkbox"/> Fixed Length Text File
<input type="checkbox"/> MS Excel	<input type="checkbox"/> Delimited Text File

12. **Contact with human subjects.** Will the study or project activities involve contact with any persons identified *within* the requested data records? Please explain the need for and the nature of the expected contact.

13. **Data management and security.** Please describe, in detail, the methods used to store the confidential data and how confidentiality of the data will be maintained.

14. **Reporting of results.** What will be the format of your results (*e.g.*, publication, grant application, poster, presentation, brochure, Web page, *etc.*)? What will be the lowest geographical level of analysis of data that will be released for publication or presentation (*e.g.*, state level, county level,

zip code, etc.)?

Section C: Data Use Agreement

Please review the accompanying Data Use Agreement. You will be asked to sign this document once your data request has been approved. By signing the DUA, you agree to the terms and conditions related to using protected health information for health related research purposes and any other terms the Vital Records Privacy Board for Health Related Research (Privacy Board) imposes as part of release of the data.

I have reviewed the request form. All statements made in the request form are true, complete, and correct to the best of my knowledge, and I agree to abide by the aforementioned stipulations.

Name of person requesting data:	Name of overall responsible party / principal investigator:
Title:	Title:
Organization:	Organization:
Signature: _____ Date: _____	Signature: _____ Date: _____

Data Set Element Selection and Justification

Please see Attachments for:

Vital Records Data – Appendix A

APPENDIX A

Vital Records Death Certificate Data Set Element Selection

Under New Hampshire law RSA 5-C:9, access to and release of most Vital Records information is restricted. For the purposes of health-related research, only the minimum necessary records and data elements will be released. Elements below with 'Need:' indicated in the third column must have a justification of why the data element is necessary for the research project or they will not be released. In the same column also supply any filtering of data records (e.g., certain causes of death) or pre-grouping of information (e.g., age groups).

Note: some unrestricted information is available to the public at the website <http://nhvrinweb.sos.nh.gov> maintained by the Division of Vital Records Administration.

Check to Request Element	Data Element	Where Indicated by "Need", Provide Justification. Also supply any filtering or grouping for the element.
<input type="checkbox"/>	State File Number	Need:
<input type="checkbox"/>	Decedent Name	Need:
<input type="checkbox"/>	Decedent Sex	
<input type="checkbox"/>	Decedent SSN	Need:
<input type="checkbox"/>	Decedent Age	
<input type="checkbox"/>	Decedent Armed Forces Flag	
<input type="checkbox"/>	Decedent Birth Date	Need:
<input type="checkbox"/>	Decedent Birth City	Need:
<input type="checkbox"/>	Decedent Birth State	
<input type="checkbox"/>	Decedent Death Date	Need:
<input type="checkbox"/>	Decedent Death Location Geography	Need:
<input type="checkbox"/>	Decedent Death Place	
<input type="checkbox"/>	Decedent Death Site in Hospital	
<input type="checkbox"/>	Decedent Death Site Other	
<input type="checkbox"/>	Decedent Marital Status	
<input type="checkbox"/>	Spouse Name	Need:
<input type="checkbox"/>	Decedent Occupation	Need:
<input type="checkbox"/>	Decedent Industry	
<input type="checkbox"/>	Decedent Industry Type	
<input type="checkbox"/>	Decedent Employer	Need:
<input type="checkbox"/>	Decedent Residence by Census Block	Need:
<input type="checkbox"/>	Decedent Residence by Census Tract	Need:
<input type="checkbox"/>	Decedent Residence Address Street	Need:
<input type="checkbox"/>	Decedent Residence Address City	Need:
<input type="checkbox"/>	Decedent Residence Address County	
<input type="checkbox"/>	Decedent Residence Address State	
<input type="checkbox"/>	Decedent Residence Address Zip code	Need:
<input type="checkbox"/>	Decedent Race	Need:
<input type="checkbox"/>	Decedent Ancestry	Need:
<input type="checkbox"/>	Decedent Hispanic Ethnicity	Need:
<input type="checkbox"/>	Decedent Education	
<input type="checkbox"/>	Father's Name	Need:

Check to Request Element	Data Element	Where Indicated by “Need”, Provide Justification. Also supply any filtering or grouping for the element.
<input type="checkbox"/>	Mother’s Name	Need:
<input type="checkbox"/>	Informants Name	Need:
<input type="checkbox"/>	Informants Address	Need:
<input type="checkbox"/>	Method of Disposition	
<input type="checkbox"/>	Place of Disposition	Need:
<input type="checkbox"/>	Disposition City & State	Need:
<input type="checkbox"/>	Disposition Date	Need:
<input type="checkbox"/>	Funeral Director Name	Need:
<input type="checkbox"/>	Funeral Director License Number	Need:
<input type="checkbox"/>	Funeral Home Name	Need:
<input type="checkbox"/>	Pronouncer’s Official Capacity	
<input type="checkbox"/>	Pronouncer’s Name	Need:
<input type="checkbox"/>	Pronouncer’s License Number	Need:
<input type="checkbox"/>	Pronouncer’s Signature Date	Need:
<input type="checkbox"/>	Pronounced Time of Death	
<input type="checkbox"/>	Pronouncer’s Date of Death	Need:
<input type="checkbox"/>	Referral to Medical Examiner Flag	
<input type="checkbox"/>	Cause of Death Text Literals	Need:
<input type="checkbox"/>	Autopsy Performed Flag	
<input type="checkbox"/>	Autopsy Findings Available Flag	
<input type="checkbox"/>	Manner of Death	
<input type="checkbox"/>	Date of Injury	
<input type="checkbox"/>	Time of Injury	
<input type="checkbox"/>	Injury at Work Flag	
<input type="checkbox"/>	Description of Injury	Need:
<input type="checkbox"/>	Place of Injury Code	
<input type="checkbox"/>	Geographic Location of Injury	Need:
<input type="checkbox"/>	Certifier’s Official Capacity	
<input type="checkbox"/>	Certifier’s Name	Need:
<input type="checkbox"/>	Certifier’s License Number	Need:
<input type="checkbox"/>	Certifier’s Signature Date	Need:
<input type="checkbox"/>	Certifier’s Address	Need:
<input type="checkbox"/>	Underlying Cause of Death Code	<i>Note, if applicable, please specify ICD codes required using ICD9 for 1998 and earlier and ICD10 for 1999 and later</i>
<input type="checkbox"/>	Birth Certificate File Number (Infants Only)	Need:
<input type="checkbox"/>	Multiple Cause of Death Codes 1 – 15	<i>Note, if applicable, please specify ICD codes required using ICD9 for 1998 and earlier and ICD10 for 1999 and later</i>
<input type="checkbox"/>	Certifiers Opinion on Tobacco Use as Contributor to Death	

Check to Request Element	Data Element	Where Indicated by “Need”, Provide Justification. Also supply any filtering or grouping for the element.
<input type="checkbox"/>	Transportation Injury Code	
<input type="checkbox"/>	Decedent Pregnancy Flag	

Vital Records Birth Certificate Data Set Element Selection

Under New Hampshire law RSA 5-C:9, access to and release of most Vital Records information is restricted. For the purposes of health-related research, only the minimum necessary records and data elements will be released. Elements below with 'Need:' indicated in the third column must have a justification of why the data element is necessary for the research project or they will not be released. In the same column also supply any filtering of data records (e.g., presence of a risk factor) or pre-grouping of information (e.g., age groups).

Note: some unrestricted information is available to the public at the website <http://nhvrinweb.sos.nh.gov> maintained by the Division of Vital Records Administration.

Check to Request Element	Data Element	Where Indicated by "Need", Provide Justification. Also supply any filtering or grouping for the element.
<input type="checkbox"/>	State File Number	Need:
<input type="checkbox"/>	Child Name	Need:
<input type="checkbox"/>	Child Sex	
<input type="checkbox"/>	City of Birth	Need:
<input type="checkbox"/>	State of Birth	
<input type="checkbox"/>	Type of Place of Birth	
<input type="checkbox"/>	Date of Birth	Need:
<input type="checkbox"/>	Time of Birth	Need:
<input type="checkbox"/>	Specific Facility/Address of Birth	Need:
<input type="checkbox"/>	Child's Medical Record Number	Need:
<input type="checkbox"/>	Birth Attendant Title	
<input type="checkbox"/>	Birth Attendant Address	Need:
<input type="checkbox"/>	Birth Attendant Name	Need:
<input type="checkbox"/>	Certifier Name	Need:
<input type="checkbox"/>	Certifier Title	
<input type="checkbox"/>	Date Certifier Signed	Need:
<input type="checkbox"/>	Mother's Medical Record Number	Need:
<input type="checkbox"/>	Mother's Name	Need:
<input type="checkbox"/>	Mother's Maiden Name	Need:
<input type="checkbox"/>	Mother's Date of Birth	Need:
<input type="checkbox"/>	Mother's Age	
<input type="checkbox"/>	Mother's State of Birth	
<input type="checkbox"/>	Mother's Residence by Census Block	Need:
<input type="checkbox"/>	Mother's Residence by Census Tract	Need:
<input type="checkbox"/>	Mother's Residence Street Address	Need:
<input type="checkbox"/>	Mother's Residence City	Need:
<input type="checkbox"/>	Mother's Residence County	
<input type="checkbox"/>	Mother's Residence State	

Check to Request Element	Data Element	Where Indicated by “Need”, Provide Justification. Also supply any filtering or grouping for the element.
<input type="checkbox"/>	Mother’s Residence Zip code	Need:
<input type="checkbox"/>	Mother’s Marital Status	
<input type="checkbox"/>	Mother’s Race	Need:
<input type="checkbox"/>	Mother’s Ancestry	Need:
<input type="checkbox"/>	Mother’s Hispanic Ethnicity	Need:
<input type="checkbox"/>	Mother’s Occupation	
<input type="checkbox"/>	Mother’s Industry	
<input type="checkbox"/>	Mother’s SSN	Need:
<input type="checkbox"/>	Mother’s Education	
<input type="checkbox"/>	Father’s Name	Need:
<input type="checkbox"/>	Father’s Date of Birth	Need:
<input type="checkbox"/>	Father’s Age	
<input type="checkbox"/>	Father’s State of Birth	
<input type="checkbox"/>	Father’s Race	Need:
<input type="checkbox"/>	Father’s Ancestry	Need:
<input type="checkbox"/>	Father’s Hispanic Ethnicity	Need:
<input type="checkbox"/>	Father’s Occupation	
<input type="checkbox"/>	Father’s Industry	
<input type="checkbox"/>	Father’s SSN	Need:
<input type="checkbox"/>	Father’s Education	
<input type="checkbox"/>	Method of Payment for Delivery	
<input type="checkbox"/>	Number of Live Births Now Living	
<input type="checkbox"/>	Number of Live Births Now Dead	
<input type="checkbox"/>	Number of Previous Terminations	
<input type="checkbox"/>	Date Last Live Birth	Need:
<input type="checkbox"/>	Date Last Termination	Need:
<input type="checkbox"/>	Date Last Normal Menses	Need:
<input type="checkbox"/>	Clinical Estimate of Gestation in Weeks	
<input type="checkbox"/>	Number of Prenatal Visits	
<input type="checkbox"/>	Child Birth Weight	
<input type="checkbox"/>	Birth Plurality	
<input type="checkbox"/>	Birth Order	
<input type="checkbox"/>	APGAR Score at Five Minutes	
<input type="checkbox"/>	Mother Transferred Prior to Birth	
<input type="checkbox"/>	Hospital Mother Transferred From	Need:
<input type="checkbox"/>	Mother Transferred After to Birth	
<input type="checkbox"/>	Hospital Mother Transferred To	Need:

Check to Request Element	Data Element	Where Indicated by "Need", Provide Justification. Also supply any filtering or grouping for the element.
<input type="checkbox"/>	Child Transferred After to Birth	
<input type="checkbox"/>	Hospital Child Transferred To	Need:
<input type="checkbox"/>	Child Live at Time of Report	
<input type="checkbox"/>	Medical Risk Factors	Need:
<input type="checkbox"/>	Tobacco Use	
<input type="checkbox"/>	Avg # of Cigarettes Smoked/Day 3 rd Trimester	
<input type="checkbox"/>	Obstetric Procedures	Need:
<input type="checkbox"/>	Complications of Labor and Delivery	Need:
<input type="checkbox"/>	Method of Delivery	
<input type="checkbox"/>	Abnormal Conditions of the Newborn	Need:
<input type="checkbox"/>	Congenital Anomalies of the Newborn	Need:
<input type="checkbox"/>	Number of Previous Cesarean Deliveries	
<input type="checkbox"/>	Infant Being Breast Fed	
<input type="checkbox"/>	Years Mother Lived in Residence	
<input type="checkbox"/>	Mother's Pre-pregnancy Weight	
<input type="checkbox"/>	Mother's Weight at Delivery	
<input type="checkbox"/>	Mother Received WIC	
<input type="checkbox"/>	Mother's Height	
<input type="checkbox"/>	Avg # of Cigarettes Smoked/Day 3 Months Before Pregnancy	
<input type="checkbox"/>	Avg # of Cigarettes Smoked/Day 1 st Trimester	
<input type="checkbox"/>	Avg # of Cigarettes Smoked/Day 2 nd Trimester	
<input type="checkbox"/>	Avg # of Cigarette Packs Smoked/Day 3 rd Trimester	
<input type="checkbox"/>	Avg # of Cigarette Packs Smoked/Day 3 Months Before Pregnancy	
<input type="checkbox"/>	NB Avg # of Cigarette Packs Smoked/Day 1 st Trimester	
<input type="checkbox"/>	Avg # of Cigarette Packs Smoked/Day 2 nd Trimester	
<input type="checkbox"/>	Date First Prenatal Visit	
<input type="checkbox"/>	Date Last Prenatal Visit	
<input type="checkbox"/>	APGAR Score at Ten Minutes	
<input type="checkbox"/>	Onset of Labor	
<input type="checkbox"/>	Infections Present	
<input type="checkbox"/>	Characteristics of Labor/Delivery	Need: